STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
POLICY DIRECTIVE

Policy No. DOC 4.5.29	Subject: **OFFENDER HEALTH RECORD ACCESS, RELEASE, AND RETENTION-**
Chapter 4: FACILITY/PROGRAM SERVICES	Page 1 of 3 and Attachments
Section 5: Health Care for Secure Facilities	Effective Date: May 1, 1998
Signature: /s/ Bill Slaughter, Director	Revision Dates: 07/22/05; 04/18/06

I. POLICY

The Department of Corrections facility health care units will maintain offender health record confidentiality in accordance with Montana statute and ensure that the health records of all released offenders are retained, stored, and available for future retrieval.

II. APPLICABILITY

The secure facilities that include Riverside and Pine Hills Youth Correctional Facilities, Montana State Prison, Montana Women's Prison, Treasure State Correctional Training Center and the private and regional facilities contracted to the Department of Corrections.

III. REFERENCES

A. 41-3-201; Title 50, Chapter 16; Montana Code Annotated
B. National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2003
C. ACA Standards for Juvenile Correctional Facilities, 2003
D. DOC Policy 1.5.6, Offender Records Access and Release

IV. DEFINITIONS

Chief Facility Health Officer – The health authority or nursing supervisor responsible for the facility health care services.

Health Care Providers – Licensed health care providers (e.g., physicians, nurses, psychiatrists, dentists, and mental health practitioners), including contracted or fee-for-service providers, responsible for offender health care and treatment.

Health Care Staff – Includes licensed health care providers and non-licensed health care staff (e.g., medical records staff, health care aides) responsible for offender health care administration and treatment.

V. DEPARTMENT DIRECTIVES

A. Health Record Location

1. Facility health care staff responsible for health records will:

   a. maintain offender health records in a secure location in the health care unit area;
   b. control access to offender health records; and
   c. ensure the records are inaccessible to offenders or non-health care staff.

B. Information Release

1. Health care information is protected by a right of privacy and will not be released by health care staff without offender consent *except when*:

   a. medical records are necessary for the offender's medical care and treatment;
   b. the offender specifically authorizes release to his or her attorney or other persons authorized by statute. *A copy of the signed release form will be placed in the medical file;* and
   c. information is required by employees on a need-to-know basis. *The chief facility health officer must approve these requests in consultation with Department attorneys*.

2. The following transactions will be handled in accordance with *DOC 1.5.6, Offender Records Access and Release:*

   a. release of youth offender health information;
   b. release that requires offender consent, i.e., the offender will be provided the opportunity to execute a signed release form authorizing staff to release specific information;
   c. release requests from the media and other public inquiries; and
   d. the cost of records release, including copying and mailing fees.

3. If the offender does not consent to the information release, health care staff will notify the inquiring party.

4. Offenders may review their health care records by submitting a written request to health care staff.

C. Information from an Outside Provider

1. Health care staff will not release offender health record information that was obtained from another health care provider or organization. Staff will inform the requesting party to contact the provider directly.

D. Release of Information Denial

1. Health care staff may deny the release of specific health information.
2. Decisions to deny information release must comply with state statute.
3. The health care staff member who denies the release of information must:

   a. document the reason for denial on the original release request form;
   b. date and sign the form;
   b. file the form in the offender health record; and
   c. return a copy of the form to the requesting party.

E. Mental Health Records

1. Mental health practitioners may only release mental health records with the signed consent of the offender.

2. Youth mental health records may only be released with the signed consent by a parent or legal guardian.

F. Signed Consent Exceptions

1. Health care staff may disclose health care records without signed consent under the following circumstances:

   a. evidence of child abuse;
   b. in the case of medical emergencies;
   c. for the control of certain communicable diseases;
   d. when a health care provider determines a situation presents a clear and immediate danger to others; and
   e. when requests for information are received from the Montana Departments of Justice and Administration (Risk Management Division) in which a claim of constitutionally inadequate medical care, diagnosis, or treatment has been filed against the Department of Corrections.

G. Record Retention Requirements

1. Facility health care staff will:

   a. retain offender health care records in the facility medical unit for five years after offender release to parole or discharge;
   b. store inactive health care records in a manner that:
      1) protects the record confidentiality and prevents unauthorized health care information release; and
      2) allows for timely records access and reactivation if an offender returns to the facility.

VI. CLOSING

Questions concerning this policy should be directed to the health services bureau chief.

VII. ATTACHMENTS (filed separately in electronic policy manual)

Health Information Request to Release Records (Attachment A)
Youth Health Information Request to Release Records (Attachment B)

Health Information Request to Release Records

Patient Name:

_____

DOC ID/AO Number: _____ Date of Birth: _____

Social Security Number: _____

1. I authorize the use or disclosure of the above named individual's health information as described below:

2. All health care information in your possession, whether generated by you or by any other source, may be released to me or to _____[name person] for:

_____

_____

_____[purpose of the disclosure].

3. Covering the period(s) of healthcare:
From (date) _____ to (date) _____
From (date) _____ to (date) _____

4. Information to be disclosed:

☐ Discharge Summary	☐ Progress Notes	☐ Operative Notes
☐ History & Physical	☐ Laboratory Tests	☐ Pathology Report
☐ Consultation Reports	☐ Emergency Rm Report	☐ X-ray/imaging Reports
☐ Immunization Record	☐ Complete Health Record	

☐ Other (please specify)_____

5. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV)or Hepatitis A, B or C. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand tht my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

6.The revocation is effective from the time it is communicated to the health care provider, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization is valid for up to 30 months from the date of execution below. If no expiration is specified this authorization will automatically expire six (6) months from the date of signing. This authorization does not permit the release of health care information relating to health care that the patient receives more than 6 months from the date of execution below. Mont. Code Ann. §50-16-527.

7. The Montana Department of Corrections, Montana State Prison, its health care providers, employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information pursuant to the Uniform Health Care Information Act, Mont. Code Ann. §50-16-501 through §50-16-553 or the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d..

8. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Signature of patient or patient's representative Date

Relationship to the patient

Witness Date

*This authorization is valid for up to 30 months from the date above.

NOTE: This form is pursuant to *DOC Policy 4.5.29, Confidentiality of Offender Health Records and Information,* and *DOC Policy 1.5.6, Offender Records Access and Release.*

Youth Health Information Request to Release Records

Patient Name: _____

DOC ID/JO Number: _____ Date of Birth: _____

Social Security Number: _____

1. I authorize the use or disclosure of the above named individual's health information as described below:

2. All health care information in your possession, whether generated by you or by any other source, may be released to me or to _____[name person] for:

_____

_____

_____[purpose of the disclosure].

3. Covering the period(s) of healthcare:
From (date) _____ to (date) _____
From (date) _____ to (date) _____

4. Information to be disclosed:

☐ Discharge Summary	☐ Progress Notes	☐ Operative Notes
☐ History & Physical	☐ Laboratory Tests	☐ Pathology Report
☐ Consultation Reports	☐ Emergency Rm Report	☐ X-ray/imaging Reports
☐ Immunization Record	☐ Complete Health Record	

☐ Other (please specify)_____

5. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV)or Hepatitis A, B or C. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

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7. The Montana Department of Corrections, Youth Services Division, its health care providers, employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information pursuant to the Uniform Health Care Information Act, Mont. Code Ann. §50-16-501 through §50-16-553 or the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d..

8. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Signature of patient or patient's representative Date

Relationship to the patient

Witness Date

Signature of Patient's Parent or Guardian Date

Relationship to the patient

Witness Date

*This authorization is valid for up to 30 months from the date above.

NOTE: This form is pursuant to *DOC Policy 4.5.29, Confidentiality of Offender Health Records and Information,* and *DOC Policy 1.5.6, Offender Records Access and Release.*